Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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159 rue Cedar Bureau 403
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 27, 2017	2017_435621_0017	000473-17	Other

Licensee/Titulaire de permis

RIVERSIDE HEALTH CARE FACILITIES, INC.
110 VICTORIA AVENUE FORT FRANCES ON P9A 2B7

Long-Term Care Home/Foyer de soins de longue durée

RAINYCREST
550 OSBORNE STREET FORT FRANCES ON P9A 3T2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JULIE KUORIKOSKI (621)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): June 5 - 9, 2017.

Critical Incident System (CIS) Inspection #2017_435621_0016 and Complaint Inspection #2017_435621_0018 were conducted concurrently with this inspection.

This Other Inspection was completed for one intake relating triggers that were deferred from Resident Quality Inspection (RQI) #2017_463616_0026. The triggers involved areas regarding Recreation and Social Activities, Maintenance and Housekeeping.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), a Ward Clerk, a Maintenance Worker, the Director of Environmental Services, the interim Administrator and residents.

The Inspector also reviewed documentation including maintenance work logs, audits, maintenance policies, as well as bath and ambulatory equipment cleaning schedules.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Recreation and Social Activities

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #004	2016_463616_0026	621
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_435621_0011	621

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

During Resident Quality Inspection #2016_463616_0026, conducted during a specific time frame in November 2016, residents #002 and #003 were identified as having mobility aides which were soiled.

On two specific days in June 2017, Inspector #621 observed resident #002's and #003's mobility aids, to be heavily soiled in specified areas.

During an interview on a specified day in June 2017, PSWs #115, #116 and #117, reported to Inspector #621 that the process for cleaning resident mobility aides included the following:

1. Resident mobility aides were cleaned a specified intervals, or more often if visible soiled, according to the resident's bath schedule, by PSW staff on the night shift;
2. PSWs were to clean all mobility aides in a specific area of the home using a specific cleaning procedure;
3. If specified areas on a residents mobility aid were soiled, PSWs were to complete an additional cleaning process that was followed up by PSW staff next morning; and
4. After cleaning of a resident's mobility aide, PSWs were to sign off and date a specific cleaning record which was found in the black binder on the unit.

When PSWs #115, #116 and #117 were asked by the Inspector if they utilized other cleaning devices for deep cleaning of resident mobility aids, they reported that although it would be helpful for deep cleaning of resident mobility aids, that they were given direction from previous management of the home to discontinue washing resident mobility aids in the machine washer as it was taking too long for the mobility aids to dry. Additionally, when PSWs #115, #116 and #117 were asked to show the Inspector the binder where they signed off completion of mobility aid cleaning, they reported that they were unable to locate it at the time of inspection.

On a day in June 2017, PSW #115 reviewed the resident bath schedule and identified to Inspector #621 that resident #002 and #003’s mobility aids were to be cleaned on their first bath day each week.

On a subsequent date and time in June 2017, PSW #115 observed resident #002's and #003's mobility aids, and confirmed to the Inspector that both resident’s mobility aides were soiled, and should have been cleaned as per the bath schedules for both residents the day prior, but had not been.

During an interview on a specific day in June 2017, Ward Clerk #130, reported to Inspector #621 that they put together the PSW cleaning schedules and located them in black binders on all units in order to PSW night staff to document when mobility aid cleaning was completed. Ward Clerk #130 reported to the Inspector that they collected the binders at the end of each year and archived the completed cleaning schedules for reference. They also reported that in early 2017, PSW staff reported from a certain unit that the mobility aid cleaning schedule binder was missing, and required another binder with cleaning schedules to be provided to the unit in April 2017. When Ward Clerk #130 was asked if they were aware that the black binder with the mobility aid cleaning schedules was again missing, they reported that they had not yet been made aware.

During an interview with the Administrator on a day in June 2017, they reported to Inspector #621 that it was their expectation that PSWs on night shift cleaned all resident mobility aids twice weekly according to the bath schedule, and more if needed. Additionally, the Administrator identified that it was their expectation that PSWs utilized the machine washer to clean resident mobility aids, that hand cleaning of wheelchairs was to be done for light spot cleaning, and were not aware that PSWs were only cleaning mobility aids by hand due to direction of previous management. Finally, the Administrator reported that they expected PSW staff were documenting the completion mobility aid cleaning on the specific mobility aid cleaning record provided, and if the

paper record went missing for any reason, that PSWs notifed the Ward Clerk immediately for follow up. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home was maintained in a good state of repair.

During Resident Quality Inspection (RQI) #2016_463616_0026, conducted during a specific time frame in November 2016, three specific resident rooms were identified to be in disrepair. At the time, the three rooms were observed to have cracks around the drain of the bathroom sink, and one of the three rooms was reported during a family interview to have stains on the flooring, which the home was aware of but had not repaired.

On a specific day in June 2017, Inspector #621 observed the following:

The first resident room was observed to have:
- A bathroom sink with numerous cracks in the epoxy at the base around the drain;
- The left arm of the stainless steel toilet paper dispenser was missing in the bathroom;
- Laminate missing and chipped on the wall protector located on the right side of the resident's bed, measuring 7 centimeters (cm) by 13 cm, and 13 cm by 25 cm;
- A 7 cm by 3 cm area above the bathroom soap dispenser where paint and drywall was missing;
- Numerous gouges in the dry wall on the wall to behind and to the left of the toilet in an area measuring 3 centimeters (cm) by 30 cm;
- Paint missing and exposing steel frame of both the bathroom and entrance doors from the floor to a height of 1 meter (m);
- Drywall damage in a 60 cm by 1 m area on the wall to the left side of the closet; and
- Paint removal across the length of the heater grill under the window at the foot of the resident's bed and adjacent to the television stand.

The second resident room was observed to have:
- A sink in a shared bathroom, with numerous cracks in the epoxy at the base around the drain;
- Gouging of the drywall and paint removal in an area 3 cm by 1 m on the wall adjacent to the bathroom door;
- Paint missing with exposure of the metal frame on both the bathroom and entrance door casings from the floor to a height of 1 m;
- Drywall damage to the right of the entrance door in an area 3 cm by 1 m, found at a height of approximately 1 m from the floor;

- Drywall damage to the left of the entrance door in an area measuring 3 cm by 1 m, found at a height of approximately 1 m above the floor;
- One corner protector measuring 6 cm by 1 m missing on wall to the left of the bathroom door;
- Paint removal across a 2 m length of the heater grill under the window on the exterior wall.

The third resident room was observed to have:
- A bathroom sink with numerous cracks in the epoxy at the base around the drain;
- A large pink stain in the linoleum flooring observed in front of the window on the exterior wall, which measured approximately 1.5 m in diameter; and
- A toilet seat with dark stains embedded into the plastic.

During an interview on a day in June 2017, Maintenance Worker #113, reported to Inspector #621 that the process for notification of maintenance issues involved the home’s staff leaving a message on the maintenance shop phone, which would be retrieved by maintenance employees with a subsequent work order generated. Maintenance Worker #113 identified that they would complete repairs in order of priority, and any outstanding works orders not completed would be carried over to the next month and tracked on a worksheet titled “Phone Messages Maintenance”. Additionally, Maintenance Worker #113 reported that when a resident was discharged from a room, they would perform all painting and repairs to the room before a new resident was admitted.

Inspector #621 reviewed the May 2017 “Phone Messages Maintenance” worksheet, and found no outstanding work orders for the three rooms identified to be in disrepair.

Inspector #621 reviewed resident admissions and discharges for the three specified rooms for the previous year and identified that resident #005 had been discharged from one of the specified rooms on a day in November 2016, with resident #011 subsequently admitted to the same room 13 days later.

During an interview with resident #011 on a day in June 2017, they reported to Inspector #621 that the cracks in the sink, the stains on the toilet seat, and the large pink stain on the linoleum flooring below the window were present since their admission. Additionally they reported that there had been not room repairs completed after their admission in late November 2016.

During an interview with PSW #112 on a day in June 2016, they reported to Inspector #621 that when maintenance issues were identified in resident rooms, the staff were to call the Maintenance department phone and leave a message detailing the concern. PSW #112 identified that the floor stains found in one of the three identified resident rooms had been there for years, and that rooms that were sun facing along that side of the unit all had the same sun damage to the linoleum.

On a another day in June 2017, Maintenance Worker #113 observed the three specified resident tooms with the Inspector and confirmed the damage as found in the 2016 RQI Inspection, and by Inspector #621 on a earlier day in June 2017. Maintenance worker #113 also indicated that they were aware of the cracked sinks found in all three rooms and throughout the rest of the home, the floor stains found one of the specified rooms, as well as several other resident rooms, and reported that besides the planned replacement of flooring in three resident rooms annually, they were not aware of an action plan for sink repair or replacement, or an action plan for repairs to the three resident rooms identified by Inspector #621 and the 2016 RQI inspection team.

On another day in June 2017, Director of Environmental Services (DES) #120 observed the three specific resident rooms and confirmed to the Inspector the damage as found in the 2016 RQI Inspection, and by Inspector #621 during the current inspection.

During an interview on the same day in June 2017, DES #120, reported to Inspector #621 that they were aware of the cracks found in resident room sinks and that an audit had been completed by the home in April 2016, and a contractor had been hired to assess the issue. The DES #120 indicated that they were not aware of the outcome of the contractor's assessment, and were not able to provide a corrective plan of action for the home at the time of inspection. The DES #120 confirmed that there was no documentation to confirm that any repairs were made to resident rooms between admissions, and that there was no formal preventative maintenance audit completed by the home of resident rooms, at regular intervals, which captured this data.

On a later date in June 2017, Inspector #621 reviewed a copy of the April 2016 resident room sink audit which identified a total of 79 resident rooms, including two of the three specific rooms, which had bathroom sinks with cracks present around their drains at that time.

During an interview on a specific day in June 2017, interim Administrator #100, reported to Inspector #621 that it was their expectation that the home, including resident rooms

were kept in a good state of repair as per legislative requirements. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

Issued on this 1st day of August, 2017

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE KUORIKOSKI (621)
Inspection No. / No de l'inspection :	2017_435621_0017
Log No. / Registre no:	000473-17
Type of Inspection / Genre d'inspection:	Other
Report Date(s) / Date(s) du Rapport :	Jul 27, 2017
Licensee / Titulaire de permis :	RIVERSIDE HEALTH CARE FACILITIES, INC. 110 VICTORIA AVENUE, FORT FRANCES, ON, P9A-2B7
LTC Home / Foyer de SLD :	RAINYCREST 550 OSBORNE STREET, FORT FRANCES, ON, P9A-3T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bonnie Hughes

To RIVERSIDE HEALTH CARE FACILITIES, INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee shall ensure that:

1) Required repairs to three specific resident rooms including, but are not limited to, drywall repairs, painting, repair or replacement of wall, door and corner guard protectors, repair or replacement of damaged flooring, sinks and room accessories, are addressed.

2) An auditing process is developed and implemented at regular intervals for each resident room in the home, to identify all maintenance issues outstanding.

3) A corrective action plan is developed and implemented for all resident rooms in the home to address maintenance issues identified from resident and family requests or complaints, maintenance requests from home's staff, as well as issues identified from maintenance audit reports.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was maintained in a good state of repair.

During Resident Quality Inspection (RQI) #2016_463616_0026, conducted during a specific time frame in November 2016, three specific resident rooms were identified to be in disrepair. At the time, the three rooms were observed to have cracks around the drain of the bathroom sink, and one of the three rooms

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During an interview on a day in June 2017, Maintenance Worker #113, reported to Inspector #621 that the process for notification of maintenance issues involved the home's staff leaving a message on the maintenance shop phone, which would be retrieved by maintenance employees with a subsequent work order generated. Maintenance Worker #113 identified that they would complete repairs in order of priority, and any outstanding works orders not completed would be carried over to the next month and tracked on a worksheet titled "Phone Messages Maintenance". Additionally, Maintenance Worker #113 reported that when a resident was discharged from a room, they would perform all painting and repairs to the room before a new resident was admitted.

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On a later date in June 2017, Inspector #621 reviewed a copy of the April 2016 resident room sink audit which identified a total of 79 resident rooms, including two of the three specific rooms, which had bathroom sinks with cracks present around their drains at that time.

During an interview on a specific day in June 2017, interim Administrator #100, reported to Inspector #621 that it was their expectation that the home, including resident rooms were kept in a good state of repair as per legislative requirements. [s. 15. (2) (c)]

The decision to issue this compliance order was based on the scope being wide spread, a potential for actual harm to residents, and a compliance history which identified a voluntary plan of correction (VPC) was issued with inspection reports #2014_339579_0016 and #2016_264609_0019 over the past 36 months. (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 27th day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Kuorikoski

Service Area Office /
Bureau régional de services : Sudbury Service Area Office